3) Are **YOU** now getting any treatment for an illness or injury for which another party could be held responsible or could be covered under no-fault, automobile, or liability insurance?

YES ☐ **NO** ☒ If **YES,** Date of Illness or Injury: M M – D D – Y Y Y Y

If **YES,** Insurer Name

ADDRESS

ADDRESS

CITY STATE ZIP

SECTION C - INFORMATION ABOUT FAMILY MEMBER(S)

1) Are **YOU** getting any group health coverage through the current or previous employment of a family member?

YES ☐ **NO** ☒ (If **NO, STOP**, please sign below)

If **YES**, please provide the name of the employer that provides the group health benefits, and information about the plan:

FAMILY MEMBER'S NAME
FIRST Middle Initial FAMILY MEMBER'S SOCIAL SECURITY NO.

LAST RELATIONSHIP

EMPLOYER NAME

ADDRESS

CITY STATE ZIP

NAME OF HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

GROUP IDENTIFICATION NUMBER

POLICY NUMBER

Your Signature Is Required
John Q. Public

AREA CODE PHONE NUMBER
555 – 555 – 5555

OMB NO. 0938-0214

SAMPLE